Subpart 9. Personal Care Services

Chapter 129. Long Term Care

§12901. General Provisions

A. The purpose of personal care services is to assist individuals with functional impairments with their daily living activities. Personal care services must be provided in accordance with an approved service plan and supporting documentation. In addition, personal care services must be coordinated with the other Medicaid and non-Medicaid services being provided to the recipient and will be considered in conjunction with those other services.

B. Each recipient requesting or receiving long-term personal care services (LT-PCS) shall undergo a functional eligibility screening utilizing an eligibility screening tool called the level of care eligibility tool (LOCET), or a subsequent eligibility tool designated by the Office of Aging and Adult Services (OAAS).

C. Each LT-PCS applicant/recipient shall be assessed using a uniform assessment tool called the minimum data set-home care (MDS-HC) or a subsequent assessment tool designated by OAAS. The MDS-HC is designed to verify that an individual meets eligibility qualifications and to determine resource allocation while identifying his/her need for support in performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The MDS-HC assessment generates a score which measures the recipient's degree of self-performance of late-loss activities of daily living during the period just before the assessment.

1. The late-loss ADLs are eating, toileting, transferring and bed mobility. An individual's assessment will generate a score which is representative of the individual's degree of self-performance on these four late-loss ADLs.

D. Based on the applicant/recipient's uniform assessment score, he/she is assigned to a level of support category and is eligible for a set allocation of weekly service hours associated with that level.

1. If the applicant/recipient is allocated less than 32 hours per week and believes that he/she is entitled to more hours, the applicant/recipient or his/her responsible representative may request a fair hearing to appeal the decision.

2. The applicant/recipient may qualify for more hours if it can be demonstrated that:

a. one or more answers to the questions involving late-loss ADLs are incorrect as recorded on the assessment; or

b. he/she needs additional hours to avoid entering into a nursing facility.

E. Requests for personal care services shall be accepted from the following individuals:

1. a Medicaid recipient who wants to receive personal care services;

2. an individual who is legally responsible for a recipient who may be in need of personal care services; or

3. a responsible representative designated by the recipient to act on his/her behalf in requesting personal care services.

F. Each recipient who requests PCS has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the recipient to act on his/her behalf in the process of accessing and/or maintaining personal care services.

1. The appropriate form authorized by OAAS shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not give legal authority for that individual to independently handle the recipient's business without his/her involvement.

b. The written designation is valid until revoked by the recipient. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist and represent the recipient in the assessment, care plan development and service delivery processes; and

b. to aid the recipient in obtaining all necessary documentation for these processes.

3. No individual may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs. This includes but is not limited to:

a. the Program of All-Inclusive Care for the Elderly;

b. long-term personal care services;

c. the community choices waiver; and

d. the adult day health care waiver.

G. The Department of Health and Hospitals may remove an LT-PCS service provider from the LT-PCS provider freedom of choice list and offer freedom of choice to LT-PCS participants when:

1. one or more of the following departmental proceedings are pending against a LT-PCS participant's service provider:

a. revocation of the provider's home and community-based services license;

b. exclusion from the Medicaid Program;

c. termination from the Medicaid Program; or

d. withholding of Medicaid reimbursement as authorized by the department's surveillance and utilization review (SURS) Rule (LAC 50:I.Chapter 41);

2. the service provider fails to timely renew its home and community-based services license as required by the home and community-based services providers licensing standards Rule (LAC 48:I.Chapter 50); or

3. the service provider's assets have been seized by the Louisiana Attorney General's office.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:911 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2577 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2450 (November 2009), LR 39:2506 (September 2013), LR 41:540 (March 2015).

§12902. Participant Direction Option

A. The Office of Aging and Adult Services implements a pilot program, the Louisiana Personal Options Program (La POP), which will allow recipients who receive long term personal care services (LT-PCS) to have the option of utilizing an alternative method to receive and manage their services. Recipients may direct and manage their own services by electing to participate in La POP, rather than accessing their services through a traditional personal care agency.

1. La POP shall be implemented through a phase-in process in Department of Health and Hospitals administrative regions designated by OAAS.

2. La POP participants will use a monthly budget allowance to manage their own personal care services. Some of the monthly allowance may be used to purchase items that increase a participant's independence or substitute for his/her dependence on human assistance.

B. Participants are required to use counseling and financial management services in order to assume responsibility for directing their services and managing their budget.

1. A financial management agency is utilized to provide financial management and payroll services to La POP participants.

2. With the assistance of a services consultant, participants develop a personal support plan based on their approved plan of care and choose the individuals they wish to hire to provide the services.

C. An orientation to the Louisiana Personal Options Program, including participant roles and responsibilities, is required for all participants prior to the completion of enrollment in the program. The intent of the orientation is to provide participants with a program handbook and other tools they need to effectively and safely manage their services.

D. La POP participants may elect to discontinue participation in the program at any time. The services consultant must be notified and will begin the disenrollment process within five business days from the date of notification. A face-to-face meeting may be required if the individual remains eligible for long-term personal care services.

1. La POP services will continue until the transition to services provided by a personal care agency is completed.

2. Once disenrolled from La POP, the participant must continue to receive services through a traditional personal care services agency for a minimum of three months before re-enrollment in La POP can be considered.

E. La POP participants may be involuntarily disenrolled from the program for any of the following reasons.

1. Health, Safety and Well-being. The Office of Aging and Adult Services or its designee makes a determination that the health, safety and well-being of a participant is compromised or threatened by continued participation in La POP.

2. Change in Condition. The participant's ability to direct his/her own care diminishes to a point where he/she can no longer do so and there is no responsible representative available to direct the care.

3. Misuse of Monthly Allocation of Funds. The La POP participant or his/her responsible representative uses the monthly budgeted funds to purchase items unrelated to personal care needs or otherwise misappropriate the funds.

4. Failure to Provide Required Documentation. The participant or his/her responsible representative fails to complete and submit employee time sheets in a timely and accurate manner, or provide required documentation of expenditures and related items as prescribed in the Louisiana Personal Options Program's roles and responsibility agreement.

5. Unsafe Working Conditions. The conditions in the workplace prevent the direct service worker from performing his/her duties or threaten his/her safety. The direct service worker must document and report these situations to OAAS or its designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2578 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2507 (September 2013).

§12903. Covered Services

A. *Personal care services* are defined as those services that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs). Assistance may be either the actual performance of the personal care task for the individual or supervision and prompting so the individual performs the task by him/herself. ADLs are those personal, functional activities required by the recipient. ADLs include tasks such as:

1. eating;

2. bathing;

3. dressing;

4. grooming;

5. transferring (getting in/out of the tub, from a bed to a chair);

6. ambulation;

7. toileting; and

8. bed mobility.

B. IADLs are those activities that are considered essential but may not require performance on a daily basis. IADLs cannot be performed in the recipient's home when he/she is absent from the home. IADLs include tasks such as:

1. light housekeeping;

2. food preparation and storage;

3. shopping;

4. laundry;

5. assisting with scheduling medical appointments when necessary;

6. accompanying the recipient to medical appointments when necessary;

7. assisting the recipient to access transportation; and

8. reminding the recipient to take his/her medication as prescribed by the physician; and

9. medically non-complex tasks where the direct service worker has received the proper training pursuant to R.S. 37:1031-1034.

C. Emergency and nonemergency medical transportation is a covered Medicaid service and is available to all recipients. Non-medical transportation is not a required component of personal care services. However, providers may choose to furnish transportation for recipients during the course of providing personal care services. If transportation is furnished, the provider agency must accept any liability for their employee transporting a recipient. It is the responsibility of the provider agency to ensure that the employee has a current, valid driver's license and automobile liability insurance.

1. La POP participants may choose to use some of their monthly budget to purchase non-medical transportation.

a. If transportation is furnished, the participant must accept all liability for their employee transporting them. It is the responsibility of the participant to ensure that the employee has a current, valid driver's license and automobile liability insurance.

D. Constant or intermittent supervision and/or sitter services are not a component of personal care services.

E. La POP participants may choose to use their services budgets to pay for items that increase their independence or substitute for their dependence on human assistance. Such items must be purchased in accordance with the policies and procedures established by OAAS.

F. Personal care services may be provided by one worker for up to three long-term personal care service recipients who live together and who have a common direct service provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2578 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2507 (September 2013).

§12905. Eligibility Criteria

A. Personal care services shall be available to recipients who are 65 years of age or older, or 21 years of age or older and have a disability. Persons with a disability must as meet the disability criteria established by the Social Security Administration.

B. Recipients must meet the eligibility criteria established by OAAS or its designee. Personal care services are medically necessary if the recipient:

1. meets the medical standards for admission to a nursing facility and requires limited assistance with at least one or more activities of daily living;

2. is able, either independently or through a responsible representative, to participate in his/her care and direct the services provided by the personal care services worker. A responsible representative is defined as the person designated by the recipient to act on his/her behalf in the process of accessing and/or maintaining personal care services; and

3. faces a substantial possibility of deterioration in mental or physical condition or functioning if either home and community-based services or nursing facility services are not provided in less than 120 days. This criterion is considered met if:

a. the recipient is in a nursing facility and could be discharged if community-based services were available;

b. is likely to require nursing facility admission within the next 120 days; or

c. has a primary caregiver who has a disability or is over the age of 70.

C. Persons who are eligible to receive LT-PCS have the option of participating in La POP. To participate in La POP, the individual must:

1. give informed consent to participate;

2. be able to understand the rights, risks, and responsibilities of managing his/her own care; and

3. be willing to complete and follow a personal supports plan with the help of a services consultant; or

4. if unable to make decisions independently, have a willing personal representative who understands the rights, risks and responsibilities of managing the participant's care.

D. Persons designated as the personal representative of either an individual receiving services under LT-PCS or the La POP option may not be the paid direct service worker of the individual they are representing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2507 (September 2013).

§12907. Recipient Rights and Responsibilities

A. Recipients who receive services under the Long-Term Personal Care Services Program have the right to actively participate in the development of their plan of care and the decision-making process regarding service delivery. Recipients also have the right to freedom of choice in the selection of a provider of personal care services and to participate in the following activities:

1. interviewing and selecting the personal care worker who will be providing services in their home;

2. developing the work schedule for their personal care worker;

3. training the individual personal care worker in the specific skills necessary to maintain the recipient's independent functioning while maintaining him/her in the home;

4. developing an emergency component in the plan of care that includes a list of personal care staff who can serve as back-up when unforeseen circumstances prevent the regularly scheduled worker from providing services;

5. signing off on payroll logs and other documentation to verify staff work hours and to authorize payment;

6. evaluating the personal care worker's job performance; and

7. transferring or discharging the personal care worker assigned to provide their services;

8. an informal resolution process to address their complaints and/or concerns regarding personal care services; and

9. a formal resolution process to address those situations where the informal resolution process fails to resolve their complaint.

B. Changing Providers. Recipients may request to change PCS agencies without cause once after each three month interval during the service authorization period. Recipients may request to change PCS providers with good cause at any time during the service authorization period.

Good Cause—the failure of the provider to furnish services in compliance with the plan of care. *Good cause* shall be determined by OAAS or its designee.

C. In addition to these rights, a La POP participant has certain responsibilities, including:

1. managing their services budget in accordance with an approved personal supports plan;

2. notifying the services consultant at the earliest reasonable time of admission to a hospital, nursing facility, rehabilitation facility or any other institution;

3. interviewing, hiring, supervising and firing their direct service workers and other employer related functions;

4. completing and submitting all required paperwork in a timely manner and complying with all applicable tax and labor laws;

5. treating their employees, the services consultant and La POP staff with respect;

6. assuring that the direct service worker is on the Louisiana Direct Services Worker Registry before wages can be authorized and paid;

7. authorizing and making changes in worker wages and benefits within the authorized budget of the personal supports plan;

8. developing the work schedule for their direct service worker;

9. training the direct service worker in the specific skills necessary to maintain the participant's independent functioning to remain in the home;

10. developing a viable individualized emergency back-up plan in the personal supports plan;

11. accurately signing off on payroll logs and other documentation to verify staff work hours and authorizing payment;

12. cooperating with the Department's quality assurance, program integrity, and program evaluation activities; and

13. providing any documentation requested by the Department or its designee in a timely manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2508 (September 2013).

§12909. Standards for Participation

A. In order to participate as a personal care services provider in the Medicaid Program, an agency:

1. must comply with:

a. state licensing regulations;

b. Medicaid provider enrollment requirements;

c. the standards of care set forth by the Louisiana Board of Nursing; and

d. any federal or state laws, rules, regulations, policies and procedures contained in the Medicaid provider manual for personal care services, or other document issued by the department. Failure to do may result in sanctions;

2. must possess a current, valid home and community based services license to provide personal care attendant services issued by the Department of Health and Hospitals, Health Standards Section.

B. In addition, a Medicaid enrolled agency must:

1. maintain adequate documentation as specified by OAAS, or its designee, to support service delivery and compliance with the approved POC and will provide said documentation at the request of the department or its designee; and

2. assure that all agency staff is employed in accordance with Internal Revenue Service (IRS) and Department of Labor regulations.

C. An LT-PCS provider shall not refuse to serve any individual who chooses his agency unless there is documentation to support an inability to meet the individual's needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

1. OAAS or its designee must be immediately notified of the circumstances surrounding a refusal by a provider to render services.

2. This requirement can only be waived by OAAS or its designee.

D. OAAS or its designee is charged with the responsibility of setting the standards, monitoring the outcomes and applying administrative sanctions for failures by service providers to meet the minimum standards for participation.

1. Failure to meet the minimum standards shall result in a range of required corrective actions including, but not limited to:

a. removal from the Freedom of Choice listing;

b. a citation of deficient practice;

c. a request for corrective action plan; and/or

d. administrative sanctions.

2. Continued failure to meet the minimum standards shall result in the loss of referral of new LT-PCS recipients and/or continued enrollment as an LT-PCS provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2451 (November 2009), LR 39:2508 (September 2013).

§12910. La POP Standards for Participation

A. Direct service workers employed under LA POP must meet the same requirement as those hired by a PCS agency.

B. All workers must be employed in accordance with Internal Revenue Service (IRS) and Department of Labor regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2580 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and Office of Aging and Adult Services, LR 39:2508 (September 2013).

§12911. Staffing Requirements

A. All staff providing direct care to the recipient, whether they are employed by a PCS agency or a recipient participating in La POP, must meet the qualifications for furnishing personal care services per the licensing regulations. The direct service worker shall demonstrate empathy toward the elderly and persons with disabilities, an ability to provide care to these recipients, and the maturity and ability to deal effectively with the demands of the job.

B. Restrictions

1. The following individuals are prohibited from being reimbursed for providing services to a recipient:

a. the recipient's spouse;

b. the recipient's curator;

c. the recipient's tutor;

d. the recipient's legal guardian;

e. the recipient's designated responsible representative; or

f. the person to whom the recipient has given representative and mandate authority (also known as Power of Attorney).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2580 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2508 (September 2013).

§12912. Training

A. Training costs for direct service workers employed by La POP participants shall be paid out of the La POP participant's personal supports plan budget.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2580 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2509 (September 2013).

§12913. Service Delivery

A. Personal care services shall be provided in the recipient's home or in another location outside of the recipient's home if the provision of these services allows the recipient to participate in normal life activities pertaining to the IADLs cited in the plan of care. The recipient's home is defined as the place where he/she resides such as a house, an apartment, a boarding house, or the house or apartment of a family member or unpaid primary care-giver. IADLs cannot be performed in the recipient's home when the recipient is absent from the home.

B. The provision of services outside of the recipient's home does not include trips outside of the borders of the state without written prior approval of OAAS or its designee, through the plan of care or otherwise.

C. Participants are not permitted to receive LT-PCS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of long-term care services, and providers are prohibited from providing and billing for services under these circumstances. Participants may not live in the home of a direct support worker unless the direct support worker is related by blood or marriage to the participant.

1. The provisions of §12913.C may be waived with prior written approval by OAAS or its designee.

D. Participants are not permitted to live in homes or property owned, operated, or controlled by a provider of services who is not related by blood or marriage to the participant.

E. Place(s) of service must be documented in the plan of care and service logs.

F. It is permissible for an LT-PCS recipient to use his/her approved LT-PCS weekly allotment flexibly provided that it is done so in accordance with the recipient's preferences and personal schedule and is properly documented in accordance with OAAS policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended LR 30:2833 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Financing and the Office of Aging and Adult Services, LR 39:2509 (September 2013), LR 41:541 (March 2015).

§12915. Service Limitations

A. Personal care services shall be limited to up to 32 hours per week. Authorization of service hours shall be considered on a case-by-case basis as substantiated by the recipient's plan of care and supporting documentation.

B. There shall be no duplication of services.

1. Personal care services may not be provided while the recipient is admitted to or attending a program which provides in-home assistance with IADLs or ADLs or while the recipient is admitted to or attending a program or setting where such assistance is available to the recipient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2451 (November 2009), LR 39:2509 (September 2013).

§12917. Reimbursement Methodology

A. Reimbursement for personal care services shall be a prospective flat rate for each approved unit of service that is provided to the recipient. One quarter hour is the standard unit of service for personal care services. Reimbursement shall not be paid for the provision of less than one quarter hour of service. Additional reimbursement shall not be available for transportation furnished during the course of providing personal care services.

B. Personal Care Workers Wage Enhancement.

1. Effective February 9, 2007, an hourly wage enhancement payment in the amount of $2 will be reimbursed to providers for full-time equivalent (FTE) personal care workers who provide services to Medicaid recipients.

a. At least 75 percent of the wage enhancement shall be paid in the aggregate to personal care workers as wages. If less than 100 percent of the enhancement is paid in wages, the remainder, up to 25 percent shall be used to pay employer-related taxes, insurance and employee benefits.

2. Effective September 20, 2007, the minimum hourly rate paid to personal care workers shall be the federal minimum wage in effect on February 20, 2007 plus 75 percent of the wage enhancement or the current federal minimum wage, whichever is higher.

3. Providers shall be required to submit a certified wage register to the Department verifying the personal care workers' gross wages for the quarter ending June 30, 2005. The wage register will be used to establish a payroll baseline for each provider. It shall include the following information:

a. gross wage paid to the personal care worker(s);

b. total number of personal care hours worked; and

c. the amount paid in employee benefits.

4. A separate report shall be submitted for paid overtime.

5. The provider shall submit quarterly wage reports that verify that the 75 percent wage enhancement has been paid to the appropriate staff.

6. The provider shall submit a report, according to the Department's specifications, that will be used to measure the effectiveness of the wage enhancement.

7. The wage enhancement payments reimbursed to providers shall be subject to audit by the Department.

8. Noncompliance or failure to demonstrate that the wage enhancement was paid directly to personal care workers may result in:

a. forfeiture of eligibility for wage enhancement payments;

b. recoupment of previous wage enhancement payments;

c. Medicaid fraud charges; and

d. disenrollment in the Medicaid Program.

C. La POP Payment Methodology

1. The budget amount will be based on the number of service hours (in one-quarter hour increments) approved by OAAS or its designee multiplied by the established fee schedule rate. The product of approved hours times the fee schedule rate will be the overall budget amount. A percentage of the overall budget will be used to offset some of the administrative costs for the fiscal management agency and the counseling support functions. After the percentage has been deducted from the overall budget, the remainder will be the budget amount for the individual participant. The participant will allocate these budget funds to cover personal support services and other items in his/her approved personal support plan.

2. Expenditures shall only be made in accordance with the approved personal supports plan and the Louisiana Personal Options Program guidelines.

3. The authorized hours and fee schedule rate will be the same whether the personal care services are agency-directed or participant-directed.

D. Effective for dates of service on or after February 1, 2009, the reimbursement rate for long term personal care services shall be reduced by 3.5 percent of the rate on file as of January 31, 2009.

E. Effective for dates of service on or after August 4, 2009, the reimbursement rate for long-term personal care services shall be reduced by 4.8 percent of the rate on file as of August 3, 2009.

F. Effective for dates of service on or after August 1, 2010, the reimbursement rate for long-term personal care services shall be reduced by 4.6 percent of the rate on file as of July 31, 2010.

G. Effective for dates of service on or after January 1, 2011, the reimbursement rate for long-term personal care services shall be reduced by 5.8 percent of the rate on file as of December 31, 2010.

H. Effective for dates of service on or after April 20, 2011, shared long-term personal care services shall be reimbursed:

1. 80 percent of the rate on file as of April 19, 2011 for two participants; and

2. 70 percent of the rate on file as of April 19, 2011 for three participants.

I. Effective for dates of service on or after July 1, 2012, the reimbursement rate for long-term personal care services furnished to one participant shall be reduced by 1.5 percent of the rate on file as of June 30, 2012.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:253 (February 2008), LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1901 (September 2009), LR 36:1251 (June 2010), LR 37:3267 (November 2011), LR 39:1780 (July 2013).

§12919. Cost Reporting Requirements

A. Effective July 1, 2012, the department shall implement mandatory cost reporting requirements for providers of long-term personal care services. The cost reports will be used to verify expenditures and to support rate setting for the services rendered to Medicaid recipients.

B. Each LT-PCS provider shall complete the DHH approved cost report and submit the cost report(s) to the department no later than five months after the state fiscal year ends (June 30).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:1052 (April 2013).